FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019364

Facility Name: Central Nursing

Address: 2450 North Central Avenue (Number) Chicago (City) 60639 (Zip Code)

County: Cook

Telephone Number: (773) 889-1333 **Fax #** (773) 889-1516

IDPA ID Number: 362801271001

Date of Initial License for Current Owners: 01/01/1973

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Sanford B Alper **Telephone Number:** (847) 580-4100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Sanford B Alper - Principal

(Firm Name & Address) Kessler, Orlean, Silver & Company, P.C.
1101 Lake Cook Road Suite C Deerfield, IL 60015-5233

(Telephone) (847) 580-4100 Fax # (847) 580-4199

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 245

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,245	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,245	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	76,160	3,398	6,545	86,103	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	76,160	3,398	6,545	86,103	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.48%

D. How many bed-hold days during this year were paid by Public Aid?
1,128 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1973

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified and days of care provided

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	159,009	30,774	35,476	225,259		225,259	38,000	263,259			1
2	Food Purchase		177,094		177,094	(24,898)	152,196	0	152,196			2
3	Housekeeping	184,717	12,446		197,163		197,163	0	197,163			3
4	Laundry	999	4,962		5,961	0	5,961	0	5,961			4
5	Heat and Other Utilities			132,455	132,455		132,455	444	132,899			5
6	Maintenance		13,155	6,992	20,147		20,147	23,301	43,448			6
7	Other (specify):*			8,129	8,129		8,129	0	8,129			7
8	**TOTAL General Services**	344,725	238,431	183,052	766,208	(24,898)	741,310	61,745	803,055			8
	B. Health Care and Programs											
9	Medical Director				0		0	0	0			9
10	Nursing and Medical Records	1,488,578	53,362	940	1,542,880		1,542,880	0	1,542,880			10
10a	Therapy			33,335	33,335		33,335	0	33,335			10a
11	Activities			533	533		533	0	533			11
12	Social Services	51,754		3,910	55,664		55,664	0	55,664			12
13	Nurse Aide Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,540,332	53,362	38,718	1,632,412	0	1,632,412	0	1,632,412			16
	C. General Administration											
17	Administrative			466,647	466,647		466,647	(182,167)	284,480			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			74,560	74,560		74,560	1,071	75,631			19
20	Dues, Fees, Subscriptions & Promotions			29,446	29,446		29,446	(3,396)	26,050			20
21	Clerical & General Office Expenses	200,964	4,945	9,130	215,039		215,039	88,562	303,601			21
22	Employee Benefits & Payroll Taxes			314,428	314,428	24,898	339,326	24,346	363,672			22
23	Inservice Training & Education			1,832	1,832	(370)	1,462	0	1,462			23
24	Travel and Seminar			760	760	370	1,130	0	1,130			24
25	Other Admin. Staff Transportation				0		0	80	80			25
26	Insurance-Prop.Liab.Malpractice			204,103	204,103		204,103	0	204,103			26
27	Other (specify):* **Bad Debts**			4,509	4,509		4,509	(4,509)	0			27
28	**TOTAL General Administration**	200,964	4,945	1,105,415	1,311,324	24,898	1,336,222	(76,013)	1,260,209			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,086,021	296,738	1,327,185	3,709,944	0	3,709,944	(14,268)	3,695,676			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Central Nursing #0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			31,536	31,536		31,536	62,921	94,457			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	0	0			32
33	Real Estate Taxes				0	205,803	205,803	0	205,803			33
34	Rent-Facility & Grounds			1,411,658	1,411,658	(205,803)	1,205,855	(1,205,416)	439			34
35	Rent-Equipment & Vehicles			1,667	1,667		1,667	389	2,056			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			1,444,861	1,444,861	0	1,444,861	(1,142,106)	302,755			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		151,210		151,210		151,210	0	151,210			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			134,138	134,138		134,138	0	134,138			42
43	Other (specify):* **Enteral Feeding**		41,408		41,408		41,408	0	41,408			43
44	**TOTAL Special Cost Centers**	0	192,618	134,138	326,756	0	326,756	0	326,756			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,086,021	489,356	2,906,184	5,481,561	0	5,481,561	(1,156,374)	4,325,187			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	23,894	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,524)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(400)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,509)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(23)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ 15,438		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,171,812)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (1,171,812)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (1,156,374)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

Central Nursing

ID# 0019364

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	38,000	0	0	0	0	0	0	0	0	38,000	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	444	0	0	0	0	0	0	0	0	0	444	5
6	Maintenance	0	743	22,558	0	0	0	0	0	0	0	0	23,301	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	1,187	60,558	0	0	0	0	0	0	0	0	61,745	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(466,647)	284,480	0	0	0	0	0	0	0	0	(182,167)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,071	0	0	0	0	0	0	0	0	0	1,071	19
20	Fees, Subscriptions & Promotions	(3,524)	0	128	0	0	0	0	0	0	0	0	(3,396)	20
21	Clerical & General Office Expenses	(400)	3,887	85,075	0	0	0	0	0	0	0	0	88,562	21
22	Employee Benefits & Payroll Taxes	0	22,186	2,160	0	0	0	0	0	0	0	0	24,346	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	80	0	0	0	0	0	0	0	0	80	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(4,532)	23	0	0	0	0	0	0	0	0	0	(4,509)	27
28	**TOTAL General Administration**	(8,456)	(439,480)	371,923	0	0	0	0	0	0	0	0	(76,013)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,456)	(438,293)	432,481	0	0	0	0	0	0	0	0	(14,268)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Central Nursing # 0019364 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	23,894	34,042	4,985	0	0	0	0	0	0	0	0	62,921	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,205,416)	0	0	0	0	0	0	0	0	0	(1,205,416)	34
35	Rent-Equipment & Vehicles	0	0	389	0	0	0	0	0	0	0	0	389	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	23,894	(1,171,374)	5,374	0	0	0	0	0	0	0	0	(1,142,106)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	15,438	(1,609,667)	437,855	0	0	0	0	0	0	0	0	(1,156,374)	45

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	50.00%	Winston Manor Nursing Home	Chicago	Nivram Mng, Inc.	Lincolnwood	Management
Joseph Mermelstein	50.00%	Emerald Park Nursing Center	Evergreen Park			
		Balmoral Home	Chicago			
		Sovereign Healthcare, LLC	Chicago			
		Chicago Ridge Nursing Cener	Chicago Ridge			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 466,647	Nivram Management, Inc.	50.00%	$	$ (466,647)	1
2	V	21	Bank Charges		Nivram Management, Inc.	50.00%	71	71	2
3	V	21	Office Expenses		Nivram Management, Inc.	50.00%	1,830	1,830	3
4	V	21	Supplies		Nivram Management, Inc.	50.00%	1,986	1,986	4
5	V	27	Franchise Tax		Nivram Management, Inc.	50.00%	23	23	5
6	V	19	Accounting		Nivram Management, Inc.	50.00%	1,071	1,071	6
7	V	22	Payroll Taxes		Nivram Management, Inc.	50.00%	22,186	22,186	7
8	V	5	Utilities		Nivram Management, Inc.	50.00%	444	444	8
9	V	34	Rent		Nivram Management, Inc.	50.00%	439	439	9
10	V	6	Repairs & Maintenance		Nivram Management, Inc.	50.00%	743	743	10
11	V	34	Rent	1,205,855	Henry Mermelstein	0.00%		(1,205,855)	11
12	V	30	Depreciation		Henry Mermelstein	0.00%	34,042	34,042	12
13	V								13
14	Total			$ 1,672,502			$ 62,835	$ * (1,609,667)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Health Insurance	$	Nivram Management	50.00%	$ 2,160	$ 2,160	15
16	V	21	Moving Expense		Nivram Management	50.00%	277	277	16
17	V	35	Equipment Rental - copier		Nivram Management	50.00%	389	389	17
18	V	30	Depreciation		Nivram Management	50.00%	4,985	4,985	18
19	V	25	Auto Expense		Nivram Management	50.00%	80	80	19
20	V	20	Advertising		Nivram Management	50.00%	128	128	20
21	V	17	Commissions		Nivram Management	50.00%	3,611	3,611	21
22	V	21	Telephone		Nivram Management	50.00%	1,207	1,207	22
23	V	6	Plant Salary		Nivram Management	50.00%	22,558	22,558	23
24	V	17	Asst. Administrator		Nivram Management	50.00%	33,836	33,836	24
25	V	21	Office Manager		Nivram Management	50.00%	14,448	14,448	25
26	V	1	Dietary Supervisor		Nivram Management	50.00%	38,000	38,000	26
27	V	17	Administrator		Nivram Management	50.00%	150,000	150,000	27
28	V	17	Administrator		Nivram Management	50.00%	26,784	26,784	28
29	V	17	Administrator		Nivram Management	50.00%	70,249	70,249	29
30	V	21	Clerical		Nivram Management	50.00%	69,143	69,143	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 437,855	$ * 437,855	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrator	Administrative	None	100,000	48	60.00	Salary	$ 150,000	L 17, Col 7	1
2	Louise Mermeltein	Dietary Supervisor	Support	None	52,000	40	42.22	Salary	38,000	L 1, Col 7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00%	85,442	4	20.89	Salary	22,558	L 6, Col 7	3
4	Doreen Mermelstein	Office Manager	Administrative	None	89,112	5	13.95	Salary	14,448	L 21, Col 7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	128,164	6	20.89	Salary	33,836	L 17, Col 7	6
7	Joseph Mermeltein	Owner	Administrative	50.00%	68,216	3	28.19	Salary	26,784	L 17, Col 7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 285,626		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc.
Street Address: 6500 N. Hamlin Ave
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-7484
Fax Number: (847) 679-7494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Bank Charges	Resident Beds	1,069	6	$ 310	$	245	$ 71	1
2	21	Office Expenses	Resident Beds	1,069	6	7,983		245	1,830	2
3	21	Supplies	Resident Beds	1,069	6	8,665		245	1,986	3
4	27	Franchise Tax	Resident Beds	1,069	6	100		245	23	4
5	19	Accounting	Resident Beds	1,069	6	4,674		245	1,071	5
6	22	Payroll Taxes	Resident Beds	1,069	6	96,804		245	22,186	6
7	5	Utilities	Resident Beds	1,069	6	1,936		245	444	7
8	34	Rent	Resident Beds	1,069	6	1,917		245	439	8
9	6	Repairs and Maintainance	Resident Beds	1,069	6	3,240		245	743	9
10	22	Health Insurance	Resident Beds	1,069	6	9,425		245	2,160	10
11	21	Moving Expense	Resident Beds	1,069	6	1,210		245	277	11
12	35	Equipment Rental - copier	Resident Beds	1,069	6	1,696		245	389	12
13	30	Depreciation	Resident Beds	1,069	6	21,751		245	4,985	13
14	25	Auto Expense	Resident Beds	1,069	6	348		245	80	14
15	20	Advertising	Resident Beds	1,069	6	557		245	128	15
16	17	Commissions	Resident Beds	1,069	6	15,755		245	3,611	16
17	21	Telephone	Resident Beds	1,069	6	5,269		245	1,208	17
18	6	Plant Salary	Direct Cost	1	1	22,558	22,558	1	22,558	18
19	17	Asst. Administrator	Direct Cost	1	1	33,836	33,836	1	33,836	19
20	21	Office Manager	Direct Cost	1	1	14,448	14,448	1	14,448	20
21	1	Dietary Supervisor	Direct Cost	1	1	38,000	38,000	1	38,000	21
22	17	Administrative	Direct Cost	1	1	247,033	247,033	1	247,033	22
23	21	Clerical	Direct Cost	1	1	69,143	69,143	1	69,143	23
24										24
25	TOTALS					$ 606,658	$ 425,018		$ 466,649	25

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 0	$ 0			$ 0	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 0	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 209,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 205,803	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,797)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 209,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 205,803	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	21,887	8
1999	217,338	9
2000	198,472	10
2001	203,521	11
2002	205,803	12

2002 Tax bill = $205,803.
Leave estimate for 2003 constant at $209,600.00

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Central Nursing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0019364

CONTACT PERSON REGARDING THIS REPORT Sanford B Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-29-431-013-0000	2450 N. Central Avenue	$ 11,754.90	$ 11,754.90
2.	13-29-431-014-0000	2451 N. Central Avenue	$ 28,088.86	$ 28,088.86
3.	13-29-431-015-0000	2452 N. Central Avenue	$ 28,131.06	$ 28,131.06
4.	13-29-431-016-0000	2453 N. Central Avenue	$ 28,131.06	$ 28,131.06
5.	13-29-431-017-0000	2454 N. Central Avenue	$ 28,097.66	$ 28,097.66
6.	13-29-431-018-0000	2455 N. Central Avenue	$ 28,031.37	$ 28,031.37
7.	13-29-431-019-0000	2456 N. Central Avenue	$ 27,935.24	$ 27,935.24
8.	13-29-431-020-0000	2457 N. Central Avenue	$ 22,349.20	$ 22,349.20
9.	13-29-431-021-0000	2458 N. Central Avenue	$ 1,594.46	$ 1,594.46
10.	13-29-431-022-0000	2459 N. Central Avenue	$ 1,688.85	$ 1,688.85
		TOTALS	$ 205,802.66	$ 205,802.66

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,185 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	30,000	1973	$ 158,977	1
2					2
3	TOTALS	30,000		$ 158,977	3

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		1973	1973	$ 1,729,156	$ 34,042	30	$ 34,042	$	$ 1,729,156	4
5					(95,563)						5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler System			1976	8,246		20			8,246	9
10	Hot Water Heater			1983	2,156		10			2,156	10
11	Light Fixtures			1984	14,684		10			14,684	11
12	Roof			1984	20,000	498	20	1,000	502	19,417	12
13	Heating & Air Conditioning			1983	2,924		20	146	146	2,871	13
14	Painting & Decorating			1983	7,863		8			7,863	14
15	Doorways			1986	1,840	97	15		(97)	1,840	15
16	Elevator Upgrade			1986	1,080	57	20	54	(3)	903	16
17	Wall Corner Guard			1987	1,531	49	10		(49)	1,531	17
18	Resurface Parking Lot			1987	6,900	219	15		(219)	6,900	18
19	Additions			1988	1,200	38	20	60	22	888	19
20	Heater Foundation			1989	1,000	32	20	50	18	690	20
21	Roof			1990	7,916	251	20	396	145	5,233	21
22	Roof			1990	2,199	70	8		(70)	2,199	22
23	Various Improvements			1990	1,850		8			1,850	23
24	Cubicle Curtains			1992	11,273	358	10		(358)	11,273	24
25	HVAC Improvements			1993	8,907		10	285	285	8,907	25
26	Draperies			1993	2,700		10	90	90	2,700	26
27	Tiling			1995	6,600	169	10	660	491	5,720	27
28	Leasehold Improvements			1995	15,914		10	1,591	1,591	13,789	28
29	Generator			1996	17,527	449	10	1,753	1,304	13,439	29
30	Roof			1996	4,800	123	10	480	357	3,680	30
31	Door			1997	2,465	63	10	247	184	1,646	31
32	Wiring for Emergency System			1997	5,000	128	10	500	372	3,333	32
33	Phone System			1997	8,238		10	823	823	5,487	33
34	Achitecture			1998	6,000	154	10	600	446	3,400	34
35	Boiler, A/C, Ductwork			1998	16,664	427	10	1,666	1,239	9,441	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roofing	1998	$ 54,000	$ 1,384	10	$ 5,400	$ 4,016	$ 30,600	37
38	Parking Lot Improvements	1998	8,000		10	800	800	3,733	38
39	Elevator Improvements	1998	4,450	68	10	445	377	2,077	39
40	HVAC Improvements	1998	2,820	73	10	282	209	1,316	40
41	Fire Alarm System Doors	1999	107,500	2,757	10	10,750	7,993	50,167	41
42	Extended Walls Through Ceiling	1999	3,000	77	10	300	223	1,400	42
43	Elevator Improvements	1999	2,650	68	10	266	198	1,241	43
44	HVAC Improvements	1999	20,388	523	10	2,038	1,515	9,511	44
45	Landscape Work	1999	4,100	105	10	410	305	1,913	45
46	Elevator Improvements	2000	89,750	2,302	10	8,975	6,673	32,909	46
47	HVAC Improvements	2000	23,639	606	10	2,364	1,758	8,668	47
48	Telephone System	2000	7,500	193	10	750	557	2,750	48
49	Air Conditioning System	2001	4,000	104	10	400	296	1,200	49
50	Air Conditioning System	2001	10,800	277	10	765	488	2,295	50
51	Air Conditioning System	2001	2,500	64	10	125	61	375	51
52	Air Conditioning Improvements	2003	5,800	2,928	10	193	(2,735)		52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,171,967	$ 48,753		$ 78,706	$ 29,953	$ 2,039,397	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 96,408	$ 11,921	$ 9,641	$ (2,280)		$	71
72	Current Year Purchases	1,112	635	56	(579)	10	56	72
73	Fully Depreciated Assets	359,530			0		359,530	73
74	Nivram Management Depr.		4,985	499	(4,486)			74
75	TOTALS	$ 457,050	$ 17,541	$ 10,196	$ (7,345)		$ 359,586	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Storage	Storage Trailer	1986	$ 900	$ 0	$ 0	$ 0	4	$ 900	76
77	Administrative	1999 Oldsmobile	1999	22,218	4,269	5,555	1,286	4	22,218	77
78							0			78
79							0			79
80	TOTALS			$ 23,118	$ 4,269	$ 5,555	$ 1,286		$ 23,118	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,811,112	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 70,563	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 94,457	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 23,894	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,422,101	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ X NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 1,667 Description: Ice Makers $900 Copier $767
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	10a-3	8 visits	135				8	135	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				119,032		119,032	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Medical Supplies / Rental Other (specify): Enteral Tube Feeding	39-2 43-2					32,178 41,408		41,408	13
14	TOTAL			$ 135		$	$ 192,618	8	$ 160,575	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,024,124	$ 970,124	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	233,050	233,050	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,596	68,596	6
7	Other Prepaid Expenses	896,912	896,912	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,222,682	$ 2,168,682	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,977	13
14	Buildings, at Historical Cost		1,729,156	14
15	Leasehold Improvements, at Historical Cost	452,592	511,722	15
16	Equipment, at Historical Cost	329,417	530,429	16
17	Accumulated Depreciation (book methods)	(386,786)	(2,222,195)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	500,100	500,100	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 895,323	$ 1,208,189	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,118,005	$ 3,376,871	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 65,713	$ 65,713	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,365	59,365	30
31	Accrued Taxes Payable (excluding real estate taxes)	45,221	45,221	31
32	Accrued Real Estate Taxes(Sch.IX-B)	209,600	209,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Rent	802,260	802,260	36
37	Due to IDPA	100,669	100,669	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,282,828	$ 1,282,828	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,282,828	$ 1,282,828	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,835,177	$ 2,094,043	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,118,005	$ 3,376,871	48

*(See instructions.)

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,927,153	1
2	Restatements (describe):		2
3	2002 book depreciation correction	14,272	3
4	2002 state income tax re: depreciation correction	6,985	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,948,410	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,956,767	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(3,070,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (113,233)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,835,177	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,305,653	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,305,653	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	630	6
7	Oxygen	96,184	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 96,814	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	67,920	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 67,920	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,468	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,468	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	9,744	28
28a	Miscellaneous	122	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,866	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,496,721	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	766,208	31
32	Health Care	1,632,412	32
33	General Administration	1,311,324	33
	B. Capital Expense		
34	Ownership	1,444,861	34
	C. Ancillary Expense		
35	Special Cost Centers	192,618	35
36	Provider Participation Fee	134,138	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,481,561	40
41	**Income before Income Taxes (line 30 minus line 40)****	3,015,160	41
42	**Income Taxes**	(58,393)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,956,767	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,150	2,390	$ 80,704	$ 33.77	1
2	Assistant Director of Nursing	2,048	2,288	53,892	23.55	2
3	Registered Nurses	30,694	32,137	698,842	21.75	3
4	Licensed Practical Nurses	9,333	9,893	156,903	15.86	4
5	Nurse Aides & Orderlies	66,355	70,693	578,788	8.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,804	1,884	16,717	8.87	9
10	Activity Assistants	5,370	5,479	33,175	6.05	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,759	1,799	25,500	14.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,997	17,953	133,509	7.44	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	20,080	21,376	185,716	8.69	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,143	9,826	122,275	12.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	166,733	175,718	$ 2,086,021 *	$ 11.87	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 12,486	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	940	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	7,344	10a-3	39
40	Physical Therapy Consultant	L	500	10-3	40
41	Occupational Therapy Consultant	Y	828	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F	1,165	10a-3	43
44	Activity Consultant	E	533	11-3	44
45	Social Service Consultant	E	3,910	12-3	45
46	Other(specify) Psychiatric Consultan	S	500	10a-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 28,206		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems	Computer Support	$ 3,736
Medi.com	Computer Support	599
Systematic Management	Billing Consultant	7,005
Gary Weintraub	Legal	9,513
Kessler, Orlean, Silver	Accounting	11,375
Personnel Planners, Inc.	U/C Consultant	1,650
Richard Peelo	Medicare Consulting	4,200
Accu-Med Services	Computer Support	2,640
Omega Healthcare	Employment	30,578
Commitment Consulting	Billing Consultant	512
ADP	Payroll Service	1,752
Reed, Weitkamp, Schelle	Legal	1,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 74,560

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,727
Unemployment Compensation Insurance	12,304
FICA Taxes	149,166
Employee Health Insurance	93,338
Employee Meals	24,898
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	4,804
Other Employee Benefits	7,089
Allocation from Management	24,346
TOTAL (agree to Schedule V, line 22, col.8)	$ 363,672

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	13,521
Health Care Worker Background Check	
(Indicate # of checks performed)	
see Attached Sch. A.	12,401
Allocated from Management	128
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,050

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,130
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,130

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $9,933**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **134,138**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **24,898** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Adequate record are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.